STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH ANS HUMAN SERVICES
EARLY CHILDHOOD SERVICES BUREAU

LEGALLY CERTIFIED PROVIDER (LCP)
PROGRAMS

STATEMENT OF HEALTH FORM

_____ _____
LEGALLY CERTIFIED PROVIDER NAME: (Please Print) PV#

_____ _____
NAME: (Please Print) Phone Number

_____ _____
Address City, State, Zip

_____ _____
Social Security Number Birth Date

I am: *an applicant* applying to be a legally certified provider
☐ care will be provided in my home ☐ care will be provided in the child's home

OR

I am: ☐ the spouse of the applicant ☐ a member of the applicant's household

Applicants and household members must meet certain health requirements. As the agency responsible for approving LCP/LCI payment numbers, the Department of Public Health and Human Services (DPHHS) must ensure that the health of each provider is adequate to meet the demands of the care being provided.

Please answer the following questions by entering an "X" in the appropriate box for each question.

The CCR&R Worker overseeing the LCP/LCI materials packet and the LCP/LCI Supervisor who approves the payment number will review this form. In some cases, the answer "yes" to a question may require an evaluation or a statement from your physician or other appropriate professional to support your responses. The answer "yes" does not mean you will automatically be denied as an LCP/LCI. Your explanation or, if necessary, your physician's or other appropriate professional's statement will be taken into consideration. The purpose of the questions is to help decide if you have health problems that may affect your ability to safely provide care. Health information, which the CCR&R Worker, assesses as needing follow up will be forwarded to the LCP/LCI Supervisor. If an evaluation or statement is needed, the Supervisor will send the required information to the LCP/LCI applicant. Any evaluations, tests or visits to your physician or other professional(s) must be paid by the LCP/LCI applicant.

☐ Yes ☐ No During the past 3 years, have you had any disabling chronic conditions, or physical, mental, or emotional illness requiring care from a physician, psychologist, or other professional?

- If "Yes," please describe. Include a description of any vision or hearing problem and any limitation on mobility. Include treatment and current status. (You may use additional paper if needed.)

☐ Yes ☐ No Do you suffer from any physical or mental health limitations, which might affect your ability to provide child care?

- If "Yes," please explain. (You may use additional paper if needed.)

☐ Yes ☐ No Are you currently diagnosed, receiving therapy or medication for a mental health problem, which might affect your Ability to provide care?

- If "Yes," please explain. (There is additional room on the next page.)

☐ Yes ☐ No Have you received counseling or treatment related to chemical dependency, drugs or alcohol within the past three years?

- If "Yes," please explain. (You may use additional paper if needed.)

☐ Yes ☐ No Have you ever been addicted to drugs and/or alcohol or have you been treated for drug and/or alcohol abuse, within the past three years?

- If "Yes," please explain. (You may use additional paper if needed.)

Additional Comments:

PLEASE READ, THEN SIGN AND DATE:

I certify that I have reviewed the foregoing information supplied by me and that it is true, accurate and complete to the best of my knowledge. I further certify that I fully understand that any misstatement on my part in completing this health statement is grounds for denying my application or for revoking my payment number should one have been issued to me on the basis of the statements I have made herein. I understand this information is confidential and is to be used only by the Department of Public Health and Human Services for the administration of the Legally Certified Provider of Child Care program. I hereby consent to the use of this information for such purposes.

SIGNATURE:_____ **DATE:**_____

Please Return To: